## Polypoidal and giant molluscum contagiosum

The letter by Kumar and Dawn[1] on a case of solitary, giant penile molluscum contagiosum (MCV) merits further comment and clarification. We have observed a cardiac transplant recipient who was therapeutically immunosuppressed, with recalcitrant facial MCV, some of which are "giant MCV". This clinical entity does exist in non-HIV patients contrary to Kumar and Dawn's statement. We have just completed a clinical survey that showed a positive correlation between CDC categories B and C HIV disease and facial MCV, compared with genital lesions in stage CDC A and non-HIV clinic attenders ($p < 0.001$ Fisher's exact test) (table). The clinical and molecular study by Thompson *et al*[2] also demonstrates the facial predilection of MCV in advanced HIV disease, but not to the exclusion of genital lesions as in Petersen's study.[3] This suggests that genital MCV occurs in HIV infected patients, as a sexually acquired infection early and once established may present in an opportunist form; however, the clinical site manifesting is determined by the degree of immunosuppression.

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1 Kumar B, Dawn G. Polypoidal and giant molluscum contagiosum in an AIDS patient. *Genitourin Med* 1995;71:57.
2 Thompson CH, de Zwart-Steffe RT, Donovan B. Clinical and molecular aspects of molluscum contagiosum infection in HIV-1 positive patients. *Int J STD AIDS* 1992;3:101–6.
3 Petersen CS, Gerstoff J. Molluscum contagiosum in HIV infected patients. *Dermatology* 1992;184:19–21.

*Anatomical sites of MCV infection in patients at HIV and GUM clinics*

| *HIV status* | *Total no. patients with MCV* | *Site presentation* | |
|---|---|---|---|
| | | *Face* | *Genital/trunk/limb* |
| HIV CDC C | 12 | 12 (100%) | 0 (0%) |
| HIV CDC B | 4 | 3 (75%) | 1 (25%) |
| HIV CDC A | 3 | 0 (0%) | 3 (100%) |
| Presumptive HIV neg GUM patients | 70 | 1 (1·43%)* | 69 (98·57%) |

*Cardiac transplant recipient.

## Ignored trichomonal infestation diagnosed by Papanicolaou smear

The retrospective study of Petersen *et al*[1] on ignored trichomonal infestation diagnosed by Papanicolaou smear reiterates the value of routine saline wet-mount phase contrast microscopy as part of the diagnostic screening in the evaluation of women (and men with urethral discharge) who attend an STD clinic.[2]

A recent audit in our unit evaluating the efficacy of saline wet-mount phase contrast microscopy in the diagnosis of trichomoniasis in the period 1992–1994 confirms its continued usefulness as part of the diagnostic tool in screening attenders at a genitourinary medicine (GUM) clinic. Our unit in the north east England region serves a catchment population of about 320,000 residing in the coastal city of Sunderland and its suburbs. As a routine, after obtaining relevant medical, sexual, contraceptive histories and a genital examination, a saline wet-mount smear from the posterior vaginal fornix in women and a urethral scrape from men with urethral discharge were examined by phase contrast microscopy. They were initially scanned at × 100 looking for motile trichomonads and then at × 400 to confirm motility and morphology of trichomonads. Samples from the posterior vaginal fornix and urethral discharge were inoculated into commercially available *Oxoid Trichomonas Medium* (Basingstoke, UK Ltd), incubated at 37°C and examined after two days and seven days for motile trichomads. Gram-stained smears were done on vaginal, urethral and cervical sites including cultures for *Neisseria gonorrhoeae, Gardnerella vaginalis, Candida albicans* and *Chlamydia trachomatis* (ELISA). Serological tests were done for syphilis and hepatitis B surface antigen routinely and for HIV (I and II) antibodies on request after appropriate counselling. Cervical cytology was done according to the National Health Service Cervical Screening Programme guidelines. We modified the guidelines by screening opportunistically sexually active teenagers—those aged under 20 years, in particular sexual contact(s) of men infected with genital warts.

In the period 1992–1994, 45 cases of trichomoniasis were identified (43 women and two men). Of the men; one was a single 24 year old who attended as an asymptomatic contact. Phase contrast microscopy of saline wet-mount urethral scrape showed motile trichomonads confirmed by culture. The other was a married 34 year old who attended with a urethral discharge. Clinical examination and microscopic review of Gram-stained urethal smear and two glass urine test provided an initial diagnosis of non-gonococcal urethritis. He was commenced on a dose of 500 mg oxytetracycline twice a day for two weeks while awaiting his cultural diagnosis. Phase contrast microscopy was not done. Trichomoniasis was confirmed from culture. His contact seen elsewhere had confirmed trichomoniasis.

The mean age of the 43 women was 22·5 years, range 14–43. Of these women 44·2% (19) were aged under 20 years; 95·3% (41) declared themselves single, separated or divorced. Contraceptive use reported were; oral contraceptive pill 30·2% (13), depo-provera 4·6% (2), intra-uterine coil device 2·3% (1). No form of contraceptive use was reported by 53·4% (23) and 9·3% (4) were pregnant.

The source of referral was: 41·8% (18) were self referred, 30·2% (13) were referred by their GP, 16·7% (7) attended following a provider referral and 11·6% (5) were referred from the Antenatal Clinic or Gynaecology Department.

The reported reason for attendance was; vaginal discharge in 53·4% (23), genital wart infection 16·2% (7) and 9·3% (4) attended requesting only testing for HIV antibodies but agreed to infective screening after counselling. The rest attended for a check-up.

Other STDs identified in the women (sometimes in combination) were *Neisseria gonorrhoeae* in 4·6% (2), *Chlamydia trachomatis* 18·6% (8), *Candida albicans* 18·6% (8), genital warts 16·2% (7), *Gardnerella vaginalis* 6·9% (3), *Herpes simplex* Type 1 in 2·3% (1). An incidental finding of septate vagina was noted in a 15 year old seen because of genital warts.

In this study, saline wet-mount phase contrast microscopy identified 88·3% (38) of the women and 50% (1) of the men at the first attendance, allowing prompt treatment. Subsequent culture identified 95·3% (41) of the women and 50% (1) of the men. Opportunistic cervical cytology was done in 14 of the women and trichomoniasis was identified only in 75·3% (11) confirmed by culture.

Various hypotheses for the decline in incidence of trichomoniasis had been made,[3] but we believe that routine phase contrast microscopic examination of saline wet-mount vaginal material from the posterior fornix and urethral discharge should remain as an essential screening modality for trichomoniasis in STD clinics, recognising the failure rate of various culture medium.[4] However, direct immunofluorescence with monoclonal antibodies holds promise as a sensitive and specific alternative of cultures for the rapid detection of *Trichomonas vaginalis* in clinical specimens.[5]

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## The value of colposcopy in genitourinary medicine

In view of Griffiths' further comments on colposcopy in genitourinary medicine,[1] it seems that a brief final observation may be justified.

The original paper[2] was a retrospective report which looke back historically to 1986. The paper clearly identified that the colposcopy approach that was being explored was exactly that of the very wide use of the colposcope as practised throughout Germany, Spain, Italy and much of France and South America. Quite simply magnification of the cervix is considered to be a better way to detect a range of cervical diseases. This includes infectious and inflammatory conditions. Clearly this broad approach can